AHCCCS Technical Consortium

November 12, 2007, 2:00 PM to 3:30 PM
AHCCCS, 701 E. Jefferson St. – 3rd Floor - Gold Room

Facilitator: Lori Petre

Handouts: Encounter Updates
- 2008-0173-01-EN-RD09A (ISD Requirements and Design)
- 2007-0358-01-EN-RD02C (ISD Requirements and Design)
- 2006-0156-01-EN-RD01C (ISD Requirements and Design)
- Promote Info 2008 November

AHCCCS 5010 & ICD 10 Updates
- 5010 Comments Submitted by AZ (email)
- Proposed NPRMs Modifications to Administrative Transactions
- ICD-10 Overview

Standards Landscape (PowerPoint slides)
- HIPPA Related Standards (diagram)

Attendees: Teleconference attendees are shown with an *****

Abrazo Health
Christine Cheesman*
Liz Liska
Veronica Rivera
JoAnn Ward

ADES
Amanda Erickson*
Laura Reith*
Matt Trumbull*

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Kevin Gibson
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Todd Cassel
Walter Janzen
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AHCCCS
Deborah Burrell
Dwanna Epps
Ester Hunt
Dennis Koch
Mary Kay McDaniel
Jacqueline McElroy
Lori Petre
Brent Ratterree

Care 1st Arizona
Anna Castaneda
Brian Skjordal

Centene - Bridgeway
Carrie Skoog-Boutajrit
Monica Cervantes
Christine Davis

Iasis Healthcare
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Mark Hart

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Jennifer Schwarz*

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Marc Carren*
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Julie Shannon*
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Julie Conrad*
Kathy Steiner*

Yavapai County LTC
Becky Ducharme*
Jean Willis*

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INTRODUCTION — Lori Petre

With reactivation of the Conference Bridge, the Consortium will resume meeting quarterly.

REFERENCE AND ENCOUNTER UPDATES — Brent Ratterree

Reference Updates

AHCCCS expected to complete the single line code RF618 (provider type rate schedule table) updates for physician and physician extender provider types prior to November 1st. Instead, that update will be completed by the 15th of the month. Health Plans should look for that update November 15th FTP Reference updates. Any related P353 (rate not found on provider type table) pends for these provider types should clear during the December adjudication encounter cycle. If you have any remaining issues please let us know.

AHCCCS staff is reviewing other provider types for additional RF618 updates. We will notify you when these additional updates are ready. Meanwhile, if your research shows missing RF618 codes for other provider types, forward that information to the encounter unit.

Also under review are S430 (place of service invalid for procedure) pend errors. Our review has identified that some place of service to procedure code combinations were missed. The missed combinations have been forwarded to our clinical are for review and update. Many of the valid combinations are expected to be updated in January 2009. If you find any missing valid combinations, please forward them to the encounter unit

There have been questions regarding effective dates for valid combinations of revenue code-to-bill type and revenue code-to-procedure code. The revenue code-to-bill type and revenue code-to-procedure code relationships are AHCCCS processing rules and are based on date of service.

The encounter family planning edit has an error. A logic change will be underway to change its read from contract type to the family planning indicator on appropriate reference tables. This is not likely to go into production until March. Any family planning pend error that is valid can be left alone and these will clear when the logic change is moved into production. Anyone with questions should notify Brent.

Encounter Updates

There are three R&D documents, previously distributed, and a spreadsheet that include a list of items that are scheduled for December and March production environments (*see* meeting packet). The documents are included here as a reminder. The December list contains 2006-0156-01, Financial Balancing, which should alleviate issues with reporting Medicare COB. Another document, 2008-0173-01, Expanding Financial Fields, will increase the field size for segments currently that are too small. If you have had files rejected due to CAS field size, please submit the encounter to test; they can be dropped into the test folder now. The last document, 2007-0358-01, Professional Multiple Surgeries, is also eligible for testing now.

Many documents for the March production are not finalized yet but will be sent to Health Plans when they are completed. If you have any questions regarding these logic changes, please contact the encounter unit.

VALIDATOR / RECIPIENT UPDATES /EDI — Dennis Koch

Modifications to Validator were completed in September. The 820s and 834s now go thru validation process just like the incoming 837s.

Health Plans should be receiving NICU indicators now on your 834's. The HD segment for Part B drug has also had some modifications.

There is a new 2400 reporting loop under the 5010. In the future we are working to ensure that more ancillary files will be incorporated into the 834 to reduce the number of files. The 834 5010 will be a complete rewrite.

Of major importance is the migration to the new FTP server - Enhanced File Transfer. This is a software product from GlobalSCAPE (globalscape.com). The VPN software will no longer be required to connect to the AHCCCS FTP server. A standard web browser will suffice. Those who use a VPN router will need a secured script to AHCCCS through a regular web connection since the VPN process will not be used. IDs will be set up on a per-person basis in order to identify who is connecting to the server. This is for increase security. These IDs will have non-expiring passwords. The migration from the current FTP server to the EFT server will occur over the next several months and will utilize a parallel switch. Both systems will be up and running so that the new process can be tested. The official switch will occur on an individual readiness basis, if possible.

EDI customer support is a special group that handles EDI questions. Several staff members are monitoring that email folder and questions are welcomed.

Question: Will operations department have a single password over individual passwords?

Answer: There will be two types of IDs. The first is the service ID. This ID will be used by an automated process and restricted to a unique IP address. The second is an individual ID. This ID is assigned to a person and is not restricted by IP address.

A secondary improvement will be the creation of one folder, named EDI, for all incoming and outgoing X12 or NCPDP 5.1 transactions.

5010 & ICD 10 UPDATES — Lori Petre

Notices of Proposed Rulemaking NPRMs were released in August for a 60-day comment period. As a departure from past experience, AHCCCS reviewed the NPRMs and submitted input to this process. AHCCCS also met with executive management for their approval to invest in a detailed review of the new rules. To meet this endeavor, certain internal staff have been identified to act as "experts" and participate in internal workgroups. Additionally, we will be engaging partners at each of the Health Plans who have interest in each transaction.

Initial discussions will examine things that work or do not work well in the current exchange of transactions between AHCCCS, Health Plans, and providers. The ICD-10 will also be reviewed because of its major impact. High-level impact analysis and requirements gathering have been initiated. Another goal is to reduce duplication by removing proprietary files that can be accommodated within the implemented transactions or within other available transactions.

Consideration will be given to interested parties who want to participate in the workgroups.

STANDARDS UPDATE — Mary Kay McDaniel

Overview of Healthcare Organizations, Data Content Committees, and Designated Standards Maintenance (diagram and PowerPoint slides)

X12 5010s/NCPDP D.0

All comments regarding the 5010s have been reviewed by the standards setting organization. At this time, no major problems have been identified. Medicare wants to include data elements on the professional institutional form type but is not the force behind the move to the 5010, ICD-10. Medicare would prefer the 4010A1. Homeland security supports the ICD-10, along with the CDC and Public Health, because the 5010 allows for the data elements - improvements in diagnosis codes.

The X12/NCPDP Transactions are the universe of Data that can be used to pay a claim. It is not just "a change to the transaction". The allowed amount fields are removed. 270-271 transactions become an intelligent request/response. The sender asks is this XX covered and the response should be unique to the request, not as we are doing today

ICD-10

The move to the ICD-10 has met with opposition only because the dates do not allow enough time. No one is actually disagreeing with the need to move to the ICD-10. A one-to-one crosswalk between ICD-9 and ICD-10 has not been provided but there is a general equivalency table. AHCCCS needs to create a crosswalk with instructions how to use the data from an AHCCCS reporting perspective. Uniformity should be met at a state level.

The final rule for the claims attachment has not been completed at this time. The attachment rule is separate and apart from the move to the 5010.

The NCPDP transaction upgrade and additional transactions are supported by the industry. The rule included a covered transaction for Subrogation.

AHCCCS Claim Attachment Project

The Unsolicited 275 is a transaction providers may use to send provider notes or forms that AHCCCS requires to pay various types of claims [e.g., sterilization forms, medical records for FES, etc]. It can be sent in one of two ways: within the 275 or uploaded as an attachment. A claim can be submitted electronically, with a PWK segment with an attachment number. The U275 is submitted or the attachment uploaded. Using the provider created attachment number from the transactions a match can be made between the claim and the attachment. This process will be initiated with a pilot group.

The EPSDT forms currently used is called the Children's Preventable Health Services Attachment. The Maternal and Child Health use case which will be worked on by HITSP in 2009 will require the use of this attachment.

Standards Organizations

The major healthcare standards organizations are DHHS, NGA, NCVHS, ONC/ONCHIT, FHA, AHIC. Under DHHS are three highly relevant groups: AHRQ, SAMSA, and CMS.

The AHRQ is important in light of the grants to community health centers to improve the quality of care. The Medicare minimum data set for nursing home reporting is a case in point. This is a required Medicare form care centers must complete. Medicare made changes in the data content and to the format. In the future, care settings will sent the information to CMS and then CMS will forward the information to states, if they have requested the information. AHRQ funded a grant that allows providers to use a standard patient assessment [HL7 CDA format] and convert it to the Medicare proprietary XML format. They are also working with HL7 to build additional patient assessments standards. Nursing homes could send it for pre-authorizations. Patient assessments could use real code sets that are more specific.

SAMHSA is making real inroads at CMS re MITA, the Medicaid Information Technology Architecture. Since mental health and substance abuse challenges frequently end up in the Medicaid environment, creating a design to bring the two systems together is now considered advantageous.

NIH research also wants the ICD-10. The National Governor's Association is behind NASMD who, through the NGA, are also pressing for changes into some file formats.

The National Committee on Vital and Health Statistics was actually written into the law. This is the first time that federal law has ever named a primary external advisory group for health information policy.

The Federal Health Architecture (FHA) is moving toward a SOA environment - a real time whole e-government initiative.

The American Health Information Community (AHIC), now AHIC II, is working to pick the standards. After a 12-month adoption period, the federal government will adopt these standards. They create use cases but do not define certain details such as what the transaction is. Once the use case gets approved and is considered for standards creation, it gets moved to HITSP, who present standards they think will meet the need.

The Determinators are NIST, HISPC, HITSP, CCHIT, and NHIN.

AHIC decides what use cases will be worked on, and the Determinators identify the standards for moving the data. The "interoperability specifications" are completed by HITSP, after a public review comment period they are 'completed', voted on and if approved by AHIC, a recommendation for adoption is sent to the DHHS Secretary. If the Secretary accepts the recommendation, a notice of acceptance is printed in the Federal Register. Any federal health care system changes must then adopt those interoperability specifications.

[Comments for the standards currently out for public review are due back 11/14/08 and include Medical Home and Care Coordination, Long Term Care Assessments, and Prior-Authorization for Treatment, Payment, and Operations. Maternal and Child Health is due back 11/21/08. The Newborn use case was completed.]

Emergency Resource Messaging is for providers who are responding, i.e. 30 burn victims who require a consult. Katrina was good example of inadequacies in a major disaster. Where to move populations and how to treat large numbers of casualties are major pending issues.

The 270, 271 transactions currently in use are also used in transactions from HITSP. The CORE Phase I, Phase II, and Phase III rules are already written in to those guidelines which are written into the inoperability specifications that are coming out. The big vendors are helping to build the standards.

HITSP convene to decide standards. IHE, CAQH, and the Continua people create profiles from the standards that are already out there. There is an IHE standard for entity identification and there is a web service that is an "open source" web service that anybody who does entity identification can use. The web service standard is written. The next step is provider identification.

All of the standards being used for the NHIN are contained in the HITSP interoperability standards.

All of the data content committees have to be asked if a new standard is used. Providers do not like some of the requirements for the UB. These rules are made by NUBC. For example, providers whose claims are being kicked back because form locator 01 – the Service Address, the place of service, cannot be a PO Box. The only way to denote the place of service is the physical address in form locator 01. Knowing where the service was performed is necessary for a quality audit. This rule is created at NUBC, not a provider or payer. If a provider is unhappy with the rule, they must take it up with NUBC.

HL7 is the clinical side of the house. Hospital providers generally use the HL7 transaction exclusively internally. Now they are expected to create the X12 administrative transactions for payment. The data payers need resides within their medical systems but the only way to get it out is through their receivables. The transactions at HL7 are not built to pass the data from the provider medical system into their receivables system to get the data needed, i.e., NDC codes. NDC for Medicare may be required on UBs. The congressional budget office questioned how certain data was retrieved, i.e., how much is paid for drugs.

An Executive Order, signed into law August 22, 2006, stipulates that federally sponsored healthcare programs "shall utilize, where available, health information technology systems and products that meet recognized

interoperability standards." Federal health architecture for the federal government, including VA, has to use recognized interoperability standards. This reference includes federal employees, i.e., Tri-care, etc., but specifically excludes Medicaid. Medicaid is required by the Medicaid Information Technology Architecture {MITA] initiative to use these standards.

As of April, 2007, in order to request funding for anything other than the 50% operational match, all changes need to provide for effective progress along a systems maturity model. The federal government will then reimburse for design and implementation 90%. The requirement is to move along that maturity level. Some regional offices were appraising the 5010s to be nothing but an update to a transaction and a move from level 1 to level 1 - not level 1 to level 2. That is considered to be "just meeting the requirement" and, therefore, eligible for only 50% funding. .

Adjournment

The next Meeting will be scheduled for January or February.